

HEALTH CARE NEWS

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Rx Drug Card Appeals to Congress

by Conrad F. Meier

Congressional conference committee negotiators working to hammer out a Medicare reform bill have agreed a discount prescription drug card may be the only way to get a drug benefit into the hands of seniors by the end of the year.

A team at the Centers for Medicare and Medicaid (CMS) is working with legislative aides to flesh out the details of a drug card program. If a more comprehensive drug benefit is approved by the Medicare reform conference committee, the cards will be used as a temporary prescription benefit program until the Medicare drug coverage plan takes effect.

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Davis Signs Employer Mandate

by Diane Carol Bast

Two days before he was recalled by voters and replaced by actor Arnold Schwarzenegger, embattled California Governor Gray Davis signed a "play or pay" mandate that, if it survives court challenges, eventually would apply to all California businesses with 20 or more employees.

Many observers said SB 2, the Health Insurance Act of 2003, would never have become law if not for the recall. "It's a shell of a bill," Doug Hessel, a California employee benefits consultant, told the *San Jose Mercury News* on October 3. "Davis would never have signed this if

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Census Bureau: More Uninsured in 2002

by Conrad F. Meier

On October 2, the U.S. Census Bureau reported 43.6 million people in the U.S. were uninsured in 2002, an increase of 2.4 million over 2001 figures. The 6 percent jump was attributed primarily to a sluggish economy, which caused increased unemployment and loss of employer-provided insurance coverage.

As have past reports, the new Census Bureau analysis finds uninsurance tends to be a short-term problem: "Spells without health insurance ... tend to be short in

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Illinois Gov. Ignores Rx Warnings



Special
Report
Drug Importation
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www.illinois.gov

Illinois Governor Rod Blagojevich has proposed importing Canadian prescription drugs to lower the state's spending on Medicaid and public employee health benefits. Drug importation is illegal, and the federal government has refused to legalize the practice as it cannot guarantee the quality or safety of imported medicines.

by Steve Stanek

Illinois Governor Rod Blagojevich (D), with support from former Clinton administration political strategist and freshman U.S. Representative Rahm Emanuel (D-Illinois), hopes to make the Prairie State the first to receive permission to import drugs from Canada for use by state

employees, their dependents, and retirees.

Over a span of barely three weeks in September, Blagojevich:

- gave the Illinois Office of Special Advocate 90 days to prepare a report on drug importation from Canada for persons covered under state health insurance plans;
- petitioned the U.S. Food and Drug

Administration to waive rules barring drug importation;

- sent letters to governors across the country encouraging them to lobby the federal government to allow states to pursue drug importation;
- flew to Washington, DC to press his case personally; and

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Insurers Wrap Up Medicare Reform Ad Campaign

by Conrad F. Meier

The National Association of Health Underwriters (NAHU), in partnership with the Alliance to Improve Medicare (AIM), has just completed a national advertising campaign urging Congress to pass comprehensive Medicare reform legislation with a prescription drug benefit.

The "Don't Come Home Without It" campaign began September 26 with print and television ads that ran for four weeks in 20 states, 21 targeted Congressional districts, and inside the Beltway.

A trade association representing more than 18,000 health insurance professionals nationwide, NAHU was among the most active proponents of H.R. 1 and S. 1, the House and Senate Medicare reform bills that passed in June 2003. As a member of the AIM steering committee, NAHU has since turned its attention to the conference committee that has been working to hammer out differences between the two bills. AIM and NAHU hope to have a measure reported out of the committee and on the President's desk for signature before Congress adjourns for the year.

"NAHU believes access to affordable prescription drugs should be an integral part of an overall reform plan that addresses serious flaws in the almost 30-year-old [Medicare] program," stated Janet Trautwein, NAHU's vice president of government affairs. "We hope for the sake of our nation's current and future seniors that Congress takes advantage of this year's opportunity to approve legislation to improve Medicare and provide seniors with much-needed prescription drug coverage."

Grassroots Focus

AIM is a broad-based coalition that has worked for several years on behalf of Medicare reform. Its "Don't Come Home Without It" campaign urges voters to contact their representatives in Congress, demanding Medicare reform be completed before the session's end. The campaign also included an Internet component, targeting senior citizens and directing them to the AIM Web site for additional information and an opportunity to contact their elected representatives.

Trautwein told *Health Care News* the media campaign complemented an ongoing grassroots effort to reach more than 75,000 senior citizens nationwide. According to Trautwein, "These seniors



have received regular updates on the status of Medicare legislation in the 108th Congress and have sent more than 12,000 e-mails and faxes to congressional offices since June 2003. We believe Medicare beneficiaries should enjoy the same kind of health care choices and quality plans health insurers already offer to millions of Americans in the private insurance market.

"Some advantages of private health plans," Trautwein points out, "are they typically offer more choices and adapt more quickly to changes in medicine and technology. It is vital Congress reach a bipartisan agreement that strengthens and improves Medicare, a system on which millions of seniors depend."

AIM has developed a Web site, <http://seniorsarewaiting.org>, so seniors can write to their Congressional representatives to

encourage support for meaningful Medicare reform.

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.

INTERNET INFO

For more information on the "Don't Come Home Without It" campaign, contact Janet Trautwein, NAHU vice president of government affairs, at 703/276-3806, email jtrautwein@nahu.org or Kelly Loussedes, NAHU director of public relations, at 703/276-3835, email kloussedes@nahu.org. Visit the NAHU Web site at www.nahu.org or the AIM Web site at www.reformmedicare.org.

Census

Continued from page 1

duration—about three-quarters (74.7 percent) were over within 1 year.” Between 1996 and 1999, the most recent data available, 44 percent of the spells of uninsurance lasted between two and four months.

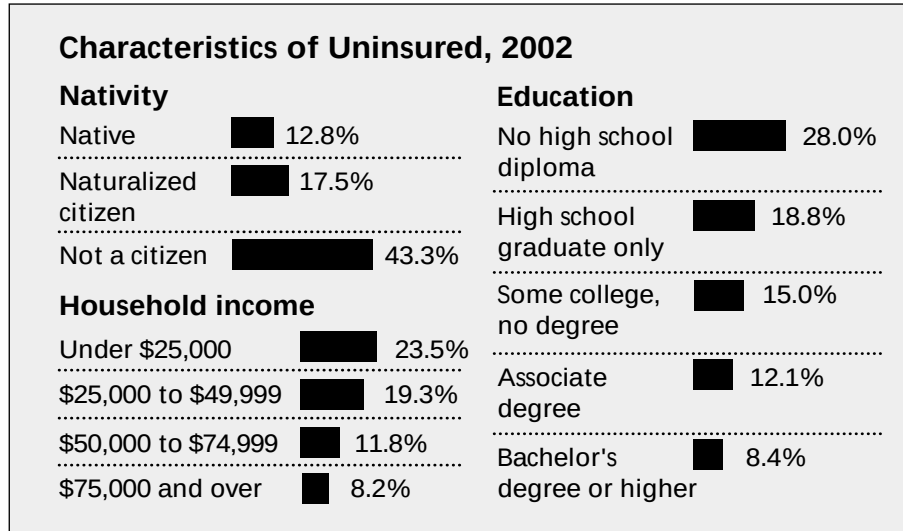
The Census Bureau counts as uninsured employees who lost their employer-provided coverage and chose not to exercise continuing health insurance coverage options available to them under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The number and percentage of children without insurance did not change between 2001 and 2002, but among most other population categories the rate of uninsurance increased. (See accompanying graph.) Most dramatically, 43.3 percent of legal and undocumented immigrants were uninsured in 2002.

Questionable Data

Robert Mills, a Census Bureau analyst, pointed to a decline in workplace-based coverage as the main reason for the increase in uninsured. In 2002, 61.3 percent of U.S. residents were covered under an employment-based insurance policy, down from 62.6 percent in 2001.

Rep. Pete Stark (D-California), a senior legislator on the Joint Economic Committee, blamed the health insurance losses on the “Bush jobless recovery.” But there is a growing debate over whether Census Bureau



and Department of Labor figures accurately capture what's happening in the labor market, the major source of health insurance.

The Department of Labor's monthly survey of 60,000 households shows 1.4 million new jobs have been created in the U.S. economy since November 2001. Its payroll survey of 400,000 businesses, however, reports 1.1 million lost jobs.

“We know the payroll survey is missing some things for sure, like a trend in self-employment,” says John Ryding, chief market analyst at the financial company Bear Stearns.

Further weakening the Census Bureau reports is evidence respondents to surveys about insurance coverage do not count government-provided health plans as insurance. The perception is understandable: Persons covered by such insurance pay no

premiums, make little or no co-payments for care, and receive no evidence of having an insurance policy.

Moreover, some people counted among the uninsured are in fact eligible for insurance, like Medicaid and the State Children's Health Insurance Programs, but have not applied. Some policymakers believe they should be regarded as insured, because they can apply when they need the insurance and can receive retroactive coverage for their expenses. Others believe such people are properly regarded as uninsured.

Tax Credits and AHPs

Claire Buchan, a spokeswoman for the Bush administration, told reporters “the President is committed to getting the economy growing faster so the number of unemployed and uninsured Americans

will go down.” Bush's 2004 budget requests \$89 billion in health care tax credits to make insurance more affordable for those who do not have employer-provided coverage.

Senator Jim Talent (R-Missouri) said he hoped the Census Bureau report would renew interest in a bill that allows small businesses to band together through national trade association health plans—AHPs—for the purpose of offering insurance to employees. The bill has passed the House but is stalled in the Senate.

“Most of these people are working people, and they're working for small businesses,” said Talent. According to Department of Labor estimates, six in 10 of the nation's uninsured work for small businesses or depend on someone who does.

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.

INTERNET INFO

More information about the Census Bureau's new report is available on the Internet at <http://www.census.gov/hhes/www/hlthin02.html>. The full text of the 24-page report, *Health Insurance Coverage in the United States: 2002*, is also available through PolicyBot, The Heartland Institute's free online research database. Point your Web browser to www.heartland.org, click on the PolicyBot icon, and search for document #13142.

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Colorado Conference Finds Answers to Rising Costs and Uninsurance Rates

by Conrad F. Meier

With health care reform measures deadlocked in Congress, the Independence Institute, a Golden, Colorado-based public policy research organization, convened a September 3, 2003 conference to explore how state officials can improve health care for their constituents—without waiting for Washington.

How We Pay

Speakers in the first session discussed how paying cash for care empowers patients.

Dr. Vern Cherewatenko described how low reimbursements and the cost of collecting third-party payments combine to bankrupt physicians. By dropping out of all insurance plans and requiring patients to pay cash, he said, physicians can eliminate about five support staff per doctor.

Physicians who have adopted this approach—which Cherewatenko devel-

“The answer,” Gorman suggested, “is to shift Medicaid towards supplementing incomes with cash, allowing people to shop for necessary care.”

oped in the late 1990s as “SimpleCare”—have been able to lower their fees by about 30 percent while remaining or becoming profitable. They also find they can devote more time to caring for patients, Cherewatenko said, without fear of running afoul of government regulations. (See “The SimpleCare Story,” *Health Care News*, February 2002.)

Greg Scandlen of the Galen Institute explained how America’s current health care financing system—which relies on employer-based insurance and government programs to cover most health care spending—emerged. “Designed decades ago,” said Scandlen, “it still assumes all customers are supported by married men who spend a lifetime with the same company and retire on Medicare. This arrangement forces consumers to accept employers and government as their health insurance agents by providing prepaid health care. Having insurers pay for all care invariably leads to excess consumption.”

That excess consumption, Scandlen said, has resulted in rationing by third-party payers—HMOs that discourage patients from seeing specialists, for example. Consumer discontent with these restrictions on choice has led to calls for government intervention, which only tends to make things worse. Experiments with limiting private-sec-



Linda Gorman, director of the Rocky Mountain Health Care Policy Center at the Independence Institute, welcomes participants in the group’s September 3 “Cash for Care” Symposium.

tor insurance to large and unexpected expenses while giving individuals cash funds to cover predictable expenses, by contrast, have increased consumer satisfaction and lowered costs.

Robert Moffit of The Heritage Foundation explained how health insurance markets in the United States are distorted by the preferential treatment given to employer-provided health insurance in the federal tax code. He also encouraged state officials to consider premium subsidies rather than direct provision of health care services. Said Moffit, “In Texas, a statewide study found roughly \$1,000 a person was already being spent on care for the uninsured [through government programs], an amount that would go a long way towards supplementing premiums for private insurance.”

According to Jim Frogue, director of the Health and Human Services Task Force of the American Legislative Exchange Council, Medicaid is the ultimate example of wasteful spending. Because patients are not expected to share the financial burden, and because states focus on increasing their federal matching funds, Medicaid reform dis-

cussions fall into two camps: “The magicians,” Frogue said, “who claim another oversight agency will cure the program’s problems; and the spendthrifts, who say more money is the answer. The result is a sterile debate over eligibility, covered benefits, reimbursement, and federal spending.”

Linda Gorman of the Independence Institute described how oversight agencies in state prescription drug formulary programs routinely deprive Medicaid patients of needed prescription drugs. “The answer,” Gorman suggested, “is to shift Medicaid towards supplementing incomes with cash, allowing people to shop for necessary care. Florida’s cash and counseling program, in which the disabled elderly receive cash that they use to buy their own care, has high consumer satisfaction, 3,000 participants, and a huge waiting list.”

Julie Reiskin of the Colorado Cross Disabilities Coalition explained cash and counseling works by circumventing the Medicaid regulatory barriers. Why, she asked, “does Medicaid require that a quadriplegic’s insulin be injected by a nurse? Why can’t a far less expensive aide be trained to do it?”

Pathways to Reform

Speakers in the second session gave blueprints for reviving moribund state health insurance markets.

Doug Dean, commissioner of the Colorado Division of Insurance, described his agency as a consumer protection agency.

Merrill Matthews of the Council for Affordable Health Insurance emphasized markets require free movement in and out of an industry free of price controls.

Lee Tooman of Golden Rule Insurance Company and Jamie Scholl of the National Association of Health Underwriters explained how coverage mandates drive reputable insurers out of the market. Colorado now has 13 insurers in the small group market. In 1994—before community rating and a mandate to define a small group as 1 to 50 employees—it had 83.

Tooman and Scholl both explained how

“Colorado now has 13 insurers in the small group market. In 1994—before community rating and a mandate to define a small group as 1 to 50 employees—it had 83.”

community rating mandates require insurers to charge sick and healthy people the same price for insurance, making insurance an expensive deal for the healthy. Eventually they stop buying and premiums skyrocket. The solution, they explained, is to allow medical underwriting, allow insurers to offer mandate-free policies, allow consumers to buy health insurance from insurers in other states, and remove the regulations preventing insurers from offering innovative products.

The Independence Institute’s Gorman told *Health Care News* the conference generated a positive response not only from participants, but from interested persons unable to attend as well.

“After the conference, the Independence Institute received dozens of requests for more information,” she noted. Moreover, “several private groups are mounting efforts to bring patient-centered health care reforms closer to reality.”

Conrad F. Meier is managing editor of *Health Care News*. His email address is meier@heartland.org. Linda Gorman, director of the Independence Institute’s Health Care Policy Center, and John Caldara, president of the Independence Institute, provided information for this report. For additional information, contact Gorman at linda@i2i.org.

Canadian Doctors Say Patients Are at Risk

by Conrad F. Meier

According to the Canadian Medical Association (CMA), the country's single-payer health care system is stretched too thin, putting Canadian patients at risk as a result.

Dr. Sunil Patel, the new president of the doctors' organization, said even before the SARS crisis, it was clear Canada was paying far too little attention to public health and emergency preparedness.

"SARS and other emerging threats have clearly illustrated the dangers of being complacent," Patel told the House of Commons finance committee. "This summer we paid a tragic price for our collective complacency."

Warnings about the poor condition of the single-payer health care system have gone unheeded by Canadian government officials. "Instead of addressing the issue, things went from bad to worse," said Patel.

The CMA is calling for \$1.5 billion in new federal spending on public health initiatives over the next five years. It says the country's top health priorities should be emergency-focused: creating a communications system to improve dissemination of crucial information to health officials during emergencies, and increased investment in emergency medical supplies.

Health Minister Anne McLellan, who

said her department had been forced to trim budgets, predicted the SARS experience would mean more spending on public health programs. While admitting the disease put a strain on the system, she insisted Canadians have not been endangered by under-funding. She defended the single-payer system, saying, "We have one of the best health care systems in the world, with pretty much the healthiest people in the world, who live the longest." (See "Patient Patients," below)

It's the Bureaucracy

Patel was quick to criticize federal and provincial governments for squabbling over a national health council to monitor health policy and accountability. Federal and provincial officials are bickering over a \$2 billion special health fund they approved last year, and the health council won't be put in place until the money issues are resolved.

Mike McBane of the Canadian Health Coalition said the national health council is doomed to failure because it expands the bureaucracy's power over health care. "It's designed not to have any independence. It's designed to be unwieldy and it's designed to ensure no governments are held to account."

According to the Canadian media, the \$2 billion would be distributed to the

provinces only if the federal government's budget surplus was large enough. But some provinces, including Ontario, have already allocated the money. Provincial Liberal Leader Dalton McGuinty (Renfrew, Ontario) said he will "fight like hell" to get Ontario's share of federal health care dollars since Ottawa may be looking to renege on money for the provinces. "I'll tell you this much," McGuinty stated. "The feds are going to have to come to the table with more health care dollars."

William Tholl, chief executive for the CMA, supported McGuinty's position, saying health care is the top priority of

Canadians. Tholl emphasized, "We need to service the health care needs of Canadians before we service the debt."

The government's position was less than encouraging. Prime Minister Jean Chrétien said it was unclear whether the money will be available and warned provinces not to count on it. "If they're spending money they don't have, it's like buying a Rolls Royce right away, but you don't have the money to pay for it," Chrétien said.

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.

Patient Patients

by Duane D. Freese

Canadian drug prices are the envy of politicians like Illinois Gov. Rod Blagojevich, who hopes to save a little money on his state's Medicaid and employee health programs by importing cheaper drugs from Canada. The governor has set this course even though it violates Food and Drug Administration regulations and even though the FDA can't guarantee the safety or effectiveness of imported medications.

Before going on that bargain buying spree, the governor might ask Canadian Linda Wilhelm of New Brunswick how Canada keeps its prescription drug prices low. Her answer certainly might give his constituents pause.

Mrs. Wilhelm, a 43-year-old mother of three, is among 4 million Canadians who suffer from some form of arthritis, the nation's largest cause of long-term disability. Her rheumatoid version, first diagnosed in 1983, has proven particularly aggressive. It has necessitated six joint replacements. Cost: \$540,000 over 10 years.

So you would think that to prevent further joint replacements and the possibility the disease might lead to more expensive treatments for glaucoma, Canada would have rushed to allow her access to a new wonder drug, Enbrel, when it came out in 1998.

A biologic, the drug virtually halts inflammation. At \$1,500 a month it was a bargain compared with the \$800 a day the government paid for hospital, home, surgical, drug, and other therapy. Further, it would immensely improve Mrs. Wilhelm's quality of life, allowing her to become fully mobile for the first time in years.

But Canadian officials, like Blagojevich, like their drugs cheap and their prices controlled. The Patented Medicines Prices Review Board (PMPRB)—Canada's FDA—won't accept clinical trials from other countries, even advanced ones such as the United States. And even after that hoop is jumped through, new drugs have to run through a gamut of provincial formulary

rules, which can keep the drugs unavailable in many parts of the nation. And that's exactly what has happened with Enbrel.

"When I first found out about the drug, I knew it was what I needed," Mrs. Wilhelm said. "My husband was afraid to go to work; my daughter was afraid to go to school, because of my condition. They didn't know if I would need carrying to the bathroom."

But the government wouldn't let her have it. Even after the Canadian federal government finally passed upon the safety and effectiveness of the drug in December 2000—more than two years after its introduction in the United States—the drug continued to require approval from a patient's provincial government before patients could get it for treatment.

"I kept phoning and writing the provincial government and kept bugging them every day. I contacted my federal MP (elected representative). The federal guys kept tossing it back to the provincial guys, who said they can't pay for it because it's not approved. Finally, I got the MP to hammer out a deal so I could take the drug on a trial basis. That was in 2001. A lot of politics."

The difference the drug has made is like night and day. "The whole life of the family used to revolve around my disease," she said. "Now I can actually go on vacation. My daughter can go to school and my husband to work without being afraid. I am no longer 75 to 80 percent disabled."

Still Rationed

But many Canadians who need the drug still can't get it even today—five years after its introduction in the United States. The U.S. pharmaceutical industry created Enbrel, as well as most other new miracle drugs. Canada produces no new drugs.

Canada keeps the prices for drugs cheap by letting others develop them, and then making its people suffer for years without access to them.

Is that the kind of devil's bargain U.S. health care consumers want?

Duane Freese is a columnist for Tech Central Station and has 26 years experience writing opinion, features, and news. His email address is dfreese@techcentralstation.com. A version of this article was first published by Tech Central Station on October 2, 2003 and is reprinted with permission.

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California

Continued from page 1

there wasn't a recall."

"Great Unknowns" Remain

The measure was introduced in December 2002 by Democrats John Burton and Jackie Speier. It passed the Senate by a vote of 25-15 on September 12, and the Assembly the following day by a vote of 46-32.

The measure gives employers with 20 or more employees two options: They must provide health insurance coverage for their employees, or they must pay a fee to the state Employment Development Department. For large employers (those with 200 or more employees), the fee would be based on the number of enrollees and dependents; for medium employers (those with 20 to 199 employees), the fee would be based on the number of enrollees only.

An "enrollee" is defined as a person who works at least 100 hours per month for an employer and has worked for that employer for at least three months.

Companies would be required to pay at least 80 percent of health premiums, or fees roughly equal to that amount; employees would pay no more than 20 percent. The contribution of low-income employees would be capped at 5 percent of their wages.

The measure would go into effect on January 1, 2006 for large employers, and

January 1, 2007 for medium employers. Employers with 20 to 49 employees would be exempt from the measure unless the state enacts a tax credit in the amount of 20 percent of the employer's net cost.

The measure creates a State Health Purchasing Program through which coverage for employees and their dependents, if applicable, would be arranged.

"There are three great unknowns" about that purchasing program, wrote *Sacramento Bee* reporter Lisa Rapaport on September 12. "The number of insur-

"The business community is right to oppose the timing of an employer-mandated health care bill in the midst of a weak economy coupled with spiraling health care costs."

SAN JOSE MERCURY NEWS

ers that decide to offer coverage through the pool, the rates those insurers offer the state, and the fees the state then charges firms to join—all of which will determine the cost of the pool and its impact on prices in the private market."

The bill does not contain cost control provisions.

"A lot of unexpected things happen when you create a big insurance pool," Mark Smith, president of the California Healthcare Foundation, told Rapaport. "You can start out with a noble idea and end up in a situation where what makes sense economically is not what people want to accept politically."

Widely Denounced

SB 2 was one of 53 bills denounced as "job killers" by the California Chamber of Commerce. In a September 13 news release, the chamber cited a study conducted by the Los Angeles Area Economic Development Corporation, which put the measure's price tag at \$5.7 billion for employers and \$1.5 billion for employees.

The California Lodging Industry Association also opposed the measure. "CLIA is very concerned with the financial impacts of SB 2 on the lodging industry and the California economy as employers throughout the state struggle to make ends meet," said Rick Lawrance, the group's president and CEO.

Even before Davis signed the measure, it was proving Lawrance's point. In late September, according to reports in the *San Jose Mercury News*, a Dallas restaurant group said it would not proceed with a planned purchase of Chevy's, a 58-restaurant chain in California, citing the cost of SB 2 as a primary reason.

The *Mercury News* editorialized on September 11 against the measure.

"According to the California Employment Development Department, [the bill] will have its greatest impact on

the fastest growing category of business in the state, businesses with between 20 and 249 employees," wrote the *Mercury News*. "The business community is right to oppose the timing of an employer-mandated health care bill in the midst of a weak economy coupled with spiraling health care costs."

According to the California Labor Federation - AFL-CIO, more than 150 labor unions and local chapters supported the bill, as did the California Medical Association and such liberal advocacy groups as the Congress of California Seniors, Health Access California, and League of Women Voters of California.

The *Mercury News* and others predict the measure will face court challenges. (See Greg Scandlen's "Consumer Choice Matters" column on page 12.) Critics say the bill violates the federal Employee Retirement Security Act (ERISA) and essentially imposes a tax that was not approved by the two-thirds majority vote required by the state constitution.

Diane Carol Bast is editor of Health Care News. Her email address is dbast@heartland.org.

INTERNET INFO

The full text of SB 2, the Health Insurance Act of 2003, is available through *PolicyBot*. Point your Web browser to www.heartland.org, click on the *PolicyBot* icon, and search for document #13143.

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*Source: "Evaluation of an Upper Extremity Student-Role Functioning Scale Using Response Theory". Authors: L.L. Schmidt et al. 1051-9815/02 2002-IOS Press.

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Why Drug Importation Endangers the Country's Drug Supply

by Grace-Marie Turner

Congress is considering federal legislation that would make importing drugs legal, not just from Canada but also from two dozen other countries. If the bill were to become law, U.S. citizens, unlicensed wholesalers, and other dealers could purchase drugs from South Africa, New Zealand, and numerous other portals, primarily in Europe.

The FDA believes allowing drug imports from Canada and other countries will open U.S. borders to unsafe, counterfeit, and contaminated drugs. Commissioner Mark McClellan has warned the importation measure before Congress "creates a wide channel for large volumes of unapproved drugs and other products to enter the United States that are potentially injurious to public health and pose a threat to the security of our Nation's drug supply."

Despite McClellan's warning, the House of Representatives approved the bill, sponsored by Minnesota Republican Gil Gutknecht, in July. It currently is being considered for inclusion in the over-all Medicare bill.

Dangerous Consequences

If the Gutknecht measure were to pass, citizens would have no idea what they are buying and where the drugs are coming from. An Internet site may have a Canadian Web address, but the drugs could easily come from a knock-off manufacturer in India or Bangladesh.

Buyers also wouldn't know if the drugs are real or fake, if they were properly manufactured and handled, or if they are contaminated or expired.

If someone gets heart medicine over the Internet and then dies, it would be difficult to determine whether the patient died from his heart ailment or because the cheaper prescription contained only sugar.

"Buyer Beware" isn't a viable defense here. While some argue the cheaper prices are worth the risk, flooding the nation with counterfeit drugs puts the whole U.S. drug supply in jeopardy.

In the early 1980s, a deranged criminal laced bottles of Tylenol with cyanide, and seven people died before the source of the poison was discovered. Every bottle of Tylenol was pulled from every shelf in every drug store in America until Johnson & Johnson developed tamper-proof pack-

aging. Every other over-the-counter drug manufacturer in America followed suit.

But such packaging is much more difficult to establish for prescription drugs,

"Buyers also wouldn't know if the drugs are real or fake, if they were properly manufactured and handled, or if they are contaminated or expired."

since doctors prescribe specific dosages dispensed by pharmacists who often buy the pills in bulk.

The FDA and Justice Department are alarmed at the growing number of sophisticated criminals who are obtaining manufacturing equipment that allows them to make copies of pills that appear nearly identical to the real thing. Counterfeiting prescription drugs has become almost as lucrative as printing currency, and investigations are finding organized crime is actively involved.

Protecting the Supply

The FDA is expected to issue a report soon with recommendations for protecting legitimate drugs as they move through the supply chain from manufacturers to distributors to retail pharmacies and doctors' offices.

The agency may recommend that drug manufacturers mark each pill with a harmless chemical that would identify the drug as legitimate. The manufacturers also may be required to put electronic tracking devices into each shipment to monitor it through the supply chain.

Such measures will drive up the cost of drugs, and drug manufacturers say they will be difficult to implement. One company worked for years to create a sophisticated anti-counterfeiting technology ... but the criminals copied it even before it got to market.

National and even state importation measures would serve to open U.S. borders to millions of new unregulated suppliers—and possibly counterfeiters.

Congress should focus on providing a prescription drug benefit to U.S. patients who don't have drug coverage and who have trouble paying for their medicines. Opening our borders to unsafe drugs that could threaten the safety, and lives, of millions of Americans comes with far too high a price.

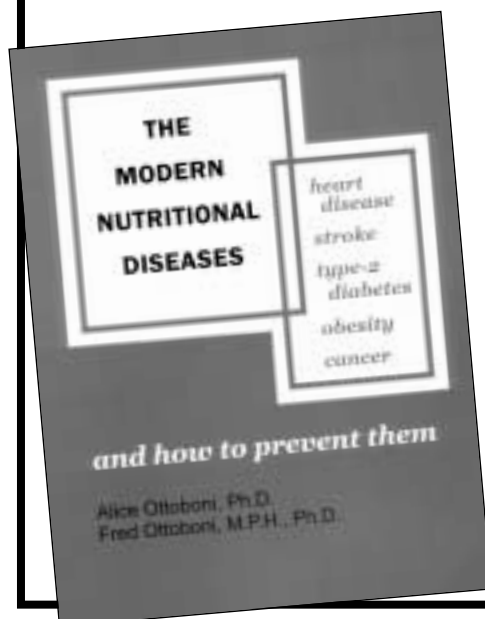
Grace-Marie Turner is president of the Galen Institute, a not-for-profit public policy research organization focusing on health reform issues. Her email address is galen@galen.org.

The Modern Nutritional Diseases and How to Prevent Them

by Alice Ottoboni, Ph.D., and Fred Ottoboni, M.P.H., Ph.D.

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Why Drug Importation Is Bad Policy

by Nina Owcharenko

As part of the fierce congressional debate over Medicare prescription drug legislation, some members of Congress want to allow Americans to import drugs subject to the price controls of Canada and other foreign countries.

Importation of drugs from Canada, or any other country, does not address the real problems of the relatively small population of seniors who are without drug coverage. It does not provide those seniors with a reliable source of coverage, and it avoids the fundamental problem facing all seniors: that Medicare is unable to adjust to the changing needs of its beneficiaries.

Importation is a distraction from the real task before Congress: comprehensive reform of the Medicare program. There are also other compelling reasons why importation is bad health care policy.

Not A Free Trade Issue

Some congressional advocates of drug importation argue it is a “free trade” issue. One of the fundamental tenets of free trade is that market forces are allowed to determine which supplies of goods and services prevail. Prescription drug prices in Canada, however, do not reflect supply and demand.

The Canadian government leverages its bulk purchasing power to “negotiate” prices with pharmaceutical manufacturers. There is no consumer-driven market for pharmaceuticals in Canada; the government dictates a fixed price with little or no regard to supply and demand in the marketplace.

Legislating Perverse Incentives

Pharmaceutical manufacturers sometimes choose to sell their products at low prices in countries, such as Canada, that impose price controls. Because those countries may represent only a small share of the global market for a drug, and because competitors face the same or similar price controls, the lost profits may not be substantial.

However, if U.S. citizens or even state governments begin to import more drugs from Canada, the pharmaceutical companies would lose more substantial sums of money on drugs sold there. At the same time, their earnings in the U.S. market would fall. To protect against these losses, pharmaceutical manufacturers would have a direct economic incentive to limit or halt entirely their sales to Canada.

That would be a difficult decision for the firms to make. In some cases, if a pharmaceutical manufacturer were unwilling to sell its products at the government-determined price, the country could allow a generic manufacturer to produce and sell a copy without the approval of the patent holder. Either course of action—conceding to price controls or losing patent protection—would weaken respect for intellectual property rights, a serious unintended consequence with repercussions that would be felt worldwide.

If the U.S. federal government were to authorize importation, the added competition for a limited supply of drugs would



Photographers Showcase

Cong. Peter King (L) and Bo Dietl (R) speak on September 22, 2003 at a news conference releasing the results of an investigation into ordering prescription drugs internationally over the Internet. Dietl found many of the drugs were sold from Web sites run by questionable individuals allowing anyone, including children, to buy prescription drugs.

cause at least some drug prices in Canada to rise. This could lead the Canadian government to stop allowing U.S. citizens to “free ride” off their health care system, especially if supplies were limited by the manufacturers. If fewer drugs were available to Canadians, it is possible none would be available to U.S. consumers. That would defeat the entire intent of importation.

In the end, the effect of importation would likely be the opposite of that intended by its proponents: Prices would be more likely to increase in Canada than they would be to decrease in the United States.

Government Manipulation

Some congressional champions of drug importation see it as the first crucial step toward adopting pharmaceutical price controls in the U.S. Price controls routinely emerge as a politically attractive short-term economic policy. Politicians point to opinion polls showing public support for government caps on prices for various goods and services, including pharmaceutical drugs.

Of course, it is no easier to repeal the economic laws of supply and demand than it is to repeal the physical laws of gravity and motion. Price controls lead to shortages, and often lower quality as well. Price controls reduce spending on goods and services simply by ensuring there are fewer of those goods and services available for con-

sumers to buy.

Price controls could have a devastating effect on the quality of health care U.S. citizens receive. In the case of drugs, price controls would delay and limit access to new life-saving drugs. Research clearly shows that patients have less access to drugs and treatments in countries where government interference in the health care market is high.

Government interference, particularly price regulation, in the pharmaceutical marketplace has further side effects. It imposes costs on countries, like the United States, that champion free markets nationally and internationally. In effect, the U.S. is forced to compensate for other countries’ distortions of the market. Patients in the U.S. bear a much greater share of the research and development burden necessary to create new pharmaceutical products.

A recent study by the Tufts Center for the Study of Drug Development found pharmaceutical manufacturers spend \$897 million to develop a new drug. Only one out of every five drugs that reach human trials (Phase 1) ultimately will be approved for marketing. This crucial investment in research and development—supported by consumers in market-oriented countries and thwarted by governments in price-controlling countries—brings lifesaving drugs and treatments to the market.

Safety First

The financial aspects of importation aside, there remain significant safety concerns. In several recent testimonies, officials of the Food and Drug Administration (FDA) and other government agencies have noted the dangers associated with importation, including individual importation (the purchase of drugs from foreign sources over the Internet). In testimony on this subject last year, William Hubbard, senior associate commissioner for policy, planning, and legislation at the FDA, stated:

Currently, new drugs marketed in the United States must be approved by FDA based on demonstrated safety and efficacy. ... This “closed” regulatory system has been very successful in preventing unapproved, adulterated, or misbranded drug products from entering the U.S. stream of commerce. Legislation that would establish other distribution routes for drug products, particularly where those routes routinely transverse a U.S. border, creates a wide inlet for counterfeit drugs and other dangerous products that can be injurious to the public health and a threat to the security of our nation’s drug supply.

Similar concerns have been raised by current Health and Human Services (HHS) Secretary Tommy Thompson and former Secretary Donna Shalala. Canadian government officials have recently clarified their position on the matter, stating they could not guarantee the safety and effectiveness of drugs exported from their country.

Conclusion

The problem of prescription drugs for senior citizens is a problem of access—not price. Through insurance mechanisms, the majority of senior citizens can and do get significant discounts on the prices of brand name and generic drugs.

Importation is not a substitute for comprehensive and serious Medicare reform, the kind of reform that would fully integrate prescription drug coverage into a system of health insurance whereby competing plans offer a variety of benefit packages to satisfy the needs of consumers.

Congress should not expect American seniors to rely on another country’s flawed health care system, and should resist the temptation of a snappy “quick fix” that does not address the problem and creates others. The Medicare legislation now being considered by the House and Senate has enough “unintended consequences” already without throwing importation into the mix.

Nina Owcharenko is senior policy analyst in the Center for Health Policy Studies at The Heritage Foundation. Her email address is staff@heritage.org. This article is derived from an essay first published, with footnotes, on June 26, 2003 by The Heritage Foundation as Web-Memo #304. The full text is available on the Internet at www.heritage.org/Research/HealthCare/wm304.cfm.



Drug Importation Roulette

by Conrad F. Meier

A growing number of governors say they intend to defy federal regulators and purchase lower-cost prescription drugs from Canada. But the Bush administration is pushing back, stepping up enforcement against illegal and potentially dangerous imported drugs.

On September 29, the Food and Drug Administration (FDA) announced that an examination of 1,153 mail parcels destined for the U.S. from other countries revealed 1,019—nearly 90 percent—contained medications that violated U.S. drug safety laws. The majority contained drugs of unknown quality and originated from Third World countries.

In July 2003, Springfield, Massachusetts launched a program encouraging the city's 20,000 employees and retirees to fax their prescription drug orders to a group of Ontario pharmacies and get their medications by return mail. The city expected to cut drug benefit spending by \$4 million.

To test the safety of Springfield's program, FDA officials ordered drugs, including insulin, from Michigan-based CanaRx under an assumed name and address. Insulin is a particularly good test case because it loses effectiveness at higher temperatures and is supposed to be shipped overnight to ensure it remains chilled. According to Peter Pitts, associate FDA commissioner for external affairs, the drugs arrived in the regular mail and at room temperature.

The Real Issue

Canada, where government-mandated price controls lower drug costs, takes in \$1 billion a year for prescription drug purchases from U.S. consumers alone. Thanks largely to the Internet, Americans are buying more drugs than ever before from Canada and at least 25 other countries, including Austria, China, Ireland, Italy, Israel, and Mexico.

The FDA repeatedly warns such drugs raise serious safety concerns: They could be counterfeit, contaminated, expired, mislabeled, or mishandled. The agency won't vouch for the quality of imported foreign drugs or those sold over the Internet, since there is no way to determine the origin of the drugs, their quality, their effectiveness, or if they endanger health.

No one disputes the fact prescription drugs are more expensive in the U.S. than in other countries—a consequence, in part, of the massive investment in research and development made by U.S. pharmaceutical manufacturers. Other countries essentially free-ride off U.S. pharmaceutical innovations and protec-

tion, including Viagra. An Israeli Health Ministry spokesperson told the *Jerusalem Post*, "According to experts, 80 percent of the Viagra sold world-wide on the black market is not the real drug. What is ironic is that the black-market pills cost twice the price of Viagra gotten by prescription."

■ **Kansas City, 2002:** Authorities arrest a local pharmacist for diluting cancer drugs given to hundreds of patients while selling the medications at full price.

■ **Florida, 2003:** Concerns about the safety of drugs surfaced after prosecutors announced a grand jury had indicted 19 people on charges of watering down or selling fake prescription drugs to busi-

■ **New Jersey, 2003:** As part of the FDA's efforts to investigate rapidly growing counterfeiting activities, FDA's Office of Criminal Investigation uncovered the existence of contaminated Procrit, a drug used to stimulate the production of red blood cells in humans with severe anemia.

As a result of investigative review and laboratory testing performed by the FDA, and in cooperation with Ortho Biotech Products, L.P., medical professionals and consumers are being alerted to the existence of three lots of the counterfeit product labeled as Procrit (epoetin alfa). The firm issued a warning by letter and on its Web site (<http://www.procrit.com/counterfeit/letter.html>) because counterfeit Procrit has been found to be contaminated with harmful bacteria. FDA testing also demonstrated some of the counterfeit product contains no active ingredient at all.

Buyer Beware

In March 2000, the FDA announced that Janssen Pharmaceutica, a wholly owned subsidiary of Johnson & Johnson, would discontinue the sale of Propulsid (cisapride) in the United States. Use of the drug has been associated with 341 heart rhythm abnormalities, including 80 deaths. The drug was used as treatment for severe nighttime heartburn in adult patients with gastro-esophageal reflux disease.

The drug remains available for sale, often without a prescription, on Internet drugstore sites.

Consumers who buy prescription drugs across borders or over the borderless Internet have no assurances those drugs are safe ... or even that they will get the exact drug their doctor prescribed. No foreign source of prescription drugs accepts responsibility for harmful effects or deaths from imported drugs.

The online prescription industry devel-

"The debate over drug importation and the higher price of prescription drugs in the U.S. has distracted the public, however, from a very important issue: the health risks counterfeit medications pose to Americans."

tions for intellectual property rights, leaving Americans to foot most of the bill.

The debate over drug importation and the higher price of prescription drugs in the U.S. has distracted the public, however, from a very important issue: the health risks counterfeit medications pose to Americans.

Consider these documented examples:

■ **Turkey, 1993:** A pharmacist tries to sell baking powder to a patient as a genuine prescription drug. He is arrested by police.

■ **Haiti, 1996:** At least 88 children die after taking counterfeit antipyretic syrup for relief of pain and fever.

■ **Lebanon, 1998:** Interpol, the international police agency, says an immense factory in the Bekaa Valley may be the world's largest producer of counterfeit

nesses selling prescription medications to consumers. The drugs are often prescribed for AIDS and cancer patients.

■ **Nebraska, 2003:** A counterfeit version of Pfizer's Lipitor, the world's top-selling cholesterol-lowering medication, was recently discovered after pharmacists and patients complained their medication tasted unusually bitter and dissolved too quickly. At least six lots of 90-count bottles containing 10 mg or 20 mg tablets have been recalled because they may contain counterfeit medication.

Hank McKinnell, chairman and CEO of Pfizer, said, "While the evidence available suggests that the counterfeit Lipitor is in limited distribution, American consumers need absolute certainty that the pharmaceutical distribution system will protect them from counterfeit products."



Getty

The owner of Rx Depot Chicago, Mary Rutherford, talks with Norm Sachman outside the store. Rx Depot provides access to prescription drugs of unknown quality and safety from Canadian pharmacies. The FDA has begun court action against the company.

oped to fill perfectly legitimate needs, chief among them increased convenience and lower costs for consumers. But counterfeiting, criminal intent, deliberate misrepresentation, and patent and trademark infringement are reason enough to distrust any imported prescriptions.

Prescription Pipeline

Even though prescription drugs are tightly regulated at the legitimate manufacturing level and the legitimate pharmacy level, there exists a huge system operating mostly under the radar screen: drug distributors.

Carmen Catizone, executive director of the National Association of Boards of Pharmacy, which represents state regulators, told the *Wall Street Journal*, "There's not the tight regulation [on drug distributors] they have on either end of the spectrum. It's certainly a regulatory gap."

Federal regulators haven't always noticed what happens to drugs on their way to legitimate pharmacies, much less unregulated storefront operations, borderless pharmacies, or Internet drug stores. Drug distributors are primarily overseen by the states, and a 1988 federal law to toughen regulation hasn't been fully implemented.

The increased reporting of cases of tampering and outright counterfeit medicines showing up in imported as well as domestic drugs is putting drug distributors in a bright light. According to the FDA, for example, the 200,000 bottles of counterfeit Lipitor found in Nebraska managed to pass through the hands of dozens of distributors, undetected as counterfeit.

In 2001, 6,500 or more drug wholesalers/distributors operated domestically in the United States. Today, the business is dominated by the top three:

AmerisourceBergen, Valley Forge, Pennsylvania; Cardinal Health Inc., Dublin, Ohio; and McKesson Corp., San Francisco, California. They make up the "primary" wholesaling and distributing market.

A "secondary" market also exists, represented by distributors who often buy and sell pharmaceuticals among themselves. This market includes much smaller firms with a narrow customer base or product focus. The role of these mini-distributors has been advanced by the economics of the drug industry, where manufacturers often charge different prices for the same drug, as would be the case in selling drugs to a state Medicaid program, non-profit hospitals, or community health clinic.

Wake-Up Call

The tampering, counterfeiting, and other criminal activity described here raises questions about drug distribution and its regulation. In most cases, perfectly safe drugs leave an easy-to-follow paper trail from a legitimate manufacturer to a legitimate wholesaler to a legitimate neighborhood pharmacy. Sometimes the trail goes directly from the manufacturer to a pharmacy, hospital, or other licensed health care provider.

In other cases, though, the trail gets cold, and medicines may pass through several wholesalers and unregulated storefront and Internet operations. These outlets may have no information about the origin, quality, or safety of the drugs they are selling to consumers. It is not impossible for a manufacturer of bogus drugs to create its own distributor.

The World Health Organization estimated in 2000 that about 8 percent of bulk drugs imported to the United States are counterfeit, unapproved, or substan-

dard. The FDA has told Congress it has little information about such shipments. According to FDA officials, it would require hundreds of millions of dollars, years of planning, and additional staff to monitor the large-scale importation being suggested by Illinois Governor Rod Blagojevich and others.

Loopholes in current federal and state regulations make it difficult to follow the drug trail. Some states erect few barriers against setting up shop as a wholesaler, and no nationally applicable law requires distributors to document a drug's origin or quality as it makes its way to the consumer.

Enforcement Measures

Although the FDA does not prosecute individuals who buy imported medications, it has begun court action against Rx Depot, a chain of storefronts that facilitates drug purchases from Canada. The agency also has mounted a vigorous campaign against legislation that would legalize buying drugs from Canada and Europe.

FDA Senior Associate Commissioner William Hubbard said in a telephone briefing that H.R. 2427—the Pharmaceutical Market Access Act of 2003, sponsored by Representative Gil Gutknecht (R-Minnesota) and Rahm Emanuel (D-Illinois)—would make things worse. He said the anti-counterfeiting packaging envisioned in the bill does not exist and legalizing any type of drug importation would, according to Hubbard, "open up the floodgates to many more of these drugs and encourage people to go buy drugs no one had any regulatory oversight over."

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.

What Is Drug "Reimportation"?

by Diane Carol Bast

Drug reimportation refers to allowing prescription drugs produced for use in another country to be imported into the U.S. for sale here instead. Because these drugs were often originally manufactured in the U.S., and then exported abroad, their return to the U.S. has been termed "reimportation."

"Under current law," explains attorney Demetrios L. Kouzoukas, "only pharmaceutical manufacturers themselves are allowed to reimport prescription drugs, and even then only under the Prescription Drug Marketing Act of 1988."

Current legislative proposals for reimportation, such as the Pharmaceutical Market Access Act of 2003 (H.R. 2427), approved in the House in late July and now pending in the Senate, would allow other parties—retail pharmacies and individual patients, for example—to reimport drugs from 26 foreign countries.

Supporters of reimportation say the practice would allow U.S. patients to purchase prescription drugs at lower prices than they currently pay. The text of H.R. 2427, for example, asserts "allowing open pharmaceutical markets could save American consumers at least \$635 billion of their own money each year."

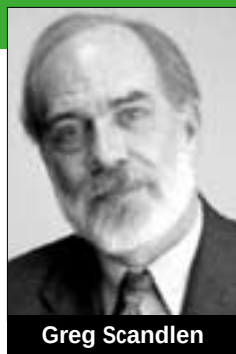
Detractors disagree, saying reimportation will limit the availability of drugs in the foreign countries from which reimportation to the U.S. is allowed. "This is exactly what happened with AIDS drugs to Africa," notes Sally Pipes of the Pacific Research Institute, "when roughly one-fifth of GlaxoSmithKline's deeply discounted AIDS shipment to Africa was resold in European markets."

Opponents of reimportation also warn of other negative consequences, among them dangers to patient safety, due to the reimportation of counterfeit drugs or those beyond their expiration dates, and reduced investment in essential research and development by pharmaceutical companies.

Diane Carol Bast is vice president of The Heartland Institute and editor of Health Care News. Her email address is dbast@heartland.org.

INTERNET INFO

For more information, see "Rx Reimportation: A Legislative History," by Demetrios L. Kouzoukas, *Health Care News*, November 2002. <http://www.heartland.org/Article.cfm?artId=10669>



Greg Scandlen

California is not only the source of wacky news about gubernatorial recalls and screwball court decisions: It is also the source of wacky legislation and screwball mandates.

The current case-in-point is the recently enacted mandate requiring all employers with more than 20 employees to provide health insurance coverage (SB 2).

Don't get too excited. This bill doesn't have a snowball's chance of surviving an ERISA (Employee Retirement Security Act) challenge. Nevertheless, it is an interesting glimpse into how the political mind works in the Golden State.

The bill would require every covered employer to provide coverage to every worker employed for at least three months and working at least 100 hours a month. The employer also would be required to pay at least 80 percent of the costs of the worker. Larger employers (more than 200 workers) must also cover 80 percent of the cost of dependents (which include domestic partners).

The workers themselves would have to pay no more than 20 percent of the cost of coverage, and the state would pay that 20 percent for those who are eligible for Medicaid ("Medi-Cal" in California parlance).

Covered employers include all those with more than 20 employees—except those with between 20 and 50 employees would be included only if the state passes a tax credit to offset 20 percent of their costs.

The bill doesn't specify benefit design, leaving it to a board to figure out, except it does say deductibles, coinsurance, and copayments shouldn't "deter enrollees from receiving appropriate and timely care."

Source: For a copy of the law as considered by California's conference committee (thanks to Neil Trautwein for passing this along):

http://info.sen.ca.gov/pub/bill/sen/sb_0001-0050/sb_2_bill_20030909_proposed.pdf

ERISA to the Rescue

State irresponsibility like this is precisely why Congress enacted ERISA in 1974. Employers said they needed predictability and consistency in their benefit programs, without having every other state forcing them to comply with some politically motivated regulation.

I know people's eyes glaze over when ERISA is mentioned, but you need to know a few things about it to put the California law into context:

1. ERISA covers all employers except churches and governments—"any employer engaged in commerce or in any industry or activity affecting commerce

...(unless) such plan is a government plan (for its own employees) (or) such plan is a church plan (for its own employees)." (Section 4 (a) and (b)). It is not confined to large employers and it is not confined to self-insured employers.

2. ERISA is unambiguous in scope. It says, "the provisions of this title shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." (Section 514(a)). This is about as broad a preemption as is possible to write.

3. ERISA "saves" from preemption state laws regulating "the business of insurance." And it "deems" an employee welfare benefit plan is not in the business of insurance (Section 514 (b)(2)(A and B)).

In a nutshell, California is allowed to regulate insurance companies until it is blue in the face, but it is not allowed to pass "any law relating to" how employers provide benefits. It could require insurance companies to sell policies for \$10 a year, and it could require residents to buy them. But it cannot require employers to provide or pay for those benefits.

Some people suppose recent court decisions on HMO restrictions (such as a recent case upholding state laws requiring HMOs to contract with "any willing provider," or other cases extending malpractice liability to HMOs) have weakened the ERISA preemption. They are mistaken.

HMOs are regulated insurance companies. ERISA has never prevented states from imposing requirements on them. Similarly, ERISA has never preempted the states' authority to regulate the practice of medicine, including malpractice remedies. To the extent an HMO

California Dreamin'

"This bill doesn't have a snowball's chance of surviving an ERISA (Employee Retirement Security Act) challenge ..."



is practicing medicine (e.g. substituting its judgment for a physician's), a state is free to regulate that practice.

But the courts have never wavered an inch from the core idea of ERISA, which says states are not allowed to tell employers what to do regarding the provision of health or pension benefits to their employees.

There is only one example to the contrary: Hawaii's employer mandate. It took an act of Congress to allow that exception, and even that exception never would have been granted but for the fact Hawaii passed its mandate about the same time ERISA was being enacted, so a case could be made that Hawaii's law should be grandfathered.

Source: For a copy of a paper I did on ERISA for the Cato Institute go to <http://www.cato.org/pubs/briefs/bp-057es.html>

NPR on California's Mandate

The media has been pretty quiet about the ERISA preemption, perhaps because of wishful thinking by the reporters or because of ignorance.

An otherwise pretty fair report by Patricia Neighmond on National Public Radio doesn't even mention ERISA. She talks about the uninsured and has a heart-wrenching tale of a woman dying because she didn't have coverage for her

blood pressure and couldn't afford a dollar-a-day for medication (it's not clear the California mandate would have helped her in any case).

The story balances out with an example of a man who owns some pizza shops with 65 employees. He calculates it would cost him \$2,000 each to provide coverage—\$130,000 per year—for which he would have to sell 130,000 more pizzas to gain the \$1.3 million in gross revenues from which he could take a 10 percent mark-up to pay the health insurance bill.

Source: <http://www.npr.org/features/feature.php?wfid=1439111>

San Diego Hopes Few Will Be Affected

An article by Leslie Berestein in the *San Diego Union Tribune* also fails to mention ERISA and minimizes the impact of the bill. "Mandated Insurance May Affect Few Here," says the headline.

The article goes on to say "only" 4,320 companies in San Diego County are big enough to be covered by the bill, and it quotes an analyst with the Kaiser Family Foundation (KFF) as saying, "Almost everybody is already doing what the law would require." Actually, it is doubtful very many are paying 80 percent of the coverage for dependents including domestic partners. The story says the sectors to be hit hardest are restaurants and manufacturing.

Source: http://www.signonsandiego.com/news/business/20030921-9999_1b21health.html

Silicon Valley Predicts \$7.2 Billion in Costs

A story by Troy May in the *Silicon Valley Business Journal* also omits any mention of ERISA, though it is not as sanguine about the legislation.

Citing KFF figures, this article reports employers with 20 to 49 workers are currently paying an average of \$2,800 for single workers and \$6,786 for families. "Medium to large firms in California could pay an additional \$5.7 billion in premiums and employees would have to pay an additional \$1.5 billion," according to the article. One business owner is quoted as saying she already is paying the "highest rates of workers' comp in the country. This legislature is hostile to business."

Source: <http://sanjose.bizjournals.com/sanjose/stories/2003/09/22/story2.html>

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Drug Card

Continued from page 1

Alternatively, the cards could be offered as a stand-alone benefit if no Medicare reform measure is passed.

CMS Administrator Thomas Scully hopes to have cards ready by April. "We've been champing at the bit to get this done," he said.

"[W]hen will Congress and the President realize that the drug card isn't part of the solution; it is the solution?"

MERRILL MATTHEWS JR., DIRECTOR
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Proven Track Record

Some 18 million Americans already use prescription drug cards, according to the General Accounting Office. The cards are offered by trade associations, pharmaceutical manufacturers, pharmacy chains, large employer groups, and some state governments.

Under the drug card plan currently being developed by CMS, all senior citizens—not only those who are low income or disabled—would be able to choose among at

least two card programs, which would differ in the copayments they require and the discounts they offer. Discounts likely would range between 10 and 25 percent, similar to the discounts offered by private-sector discount card programs.

The drug card program would be administered by health insurance companies or private pharmaceutical benefit managers (PBMs). Plan participants would be charged an annual fee—\$30 is the figure currently under consideration.

In addition to the discounts, Medicare beneficiaries with incomes below \$12,123 would be eligible for \$600 a year to spend on medications. They would pay a 5 or 10 percent co-payment when filling prescriptions, depending on their incomes.

Details, Details

Important elements of the plan—whether PBMs would be reimbursed by Medicare for their administrative costs, for example, and whether they would be required to pass on to consumers some or all of the discounts they negotiate with drug companies—still are being worked out in Congress. For that reason, the PBMs aren't committing themselves to support the plan.

Jeff Simek, a spokesman for Medco Health Solutions, noted, "The details behind the card program are critically important. But the company is very interested in being part of the solution." According to business trade journals, ExpressScripts, Advance PCS, and other

benefit managers are taking the same wait-and-see posture.

Merrill Matthews Jr., director of the Council for Affordable Health Insurance, told *Health Care News* he favors President George W. Bush's prescription drug card proposal.

"The President's discount drug card, which would include an annual subsidy of up to \$600 for low-income participants, is the best way to get help to seniors," Matthews said. "It won't cost anywhere near \$400 billion (over 10 years), it is not a costly new entitlement being piled on

top of an already financially troubled system, and it won't undermine the prescription drug coverage that 75 percent of seniors already have.

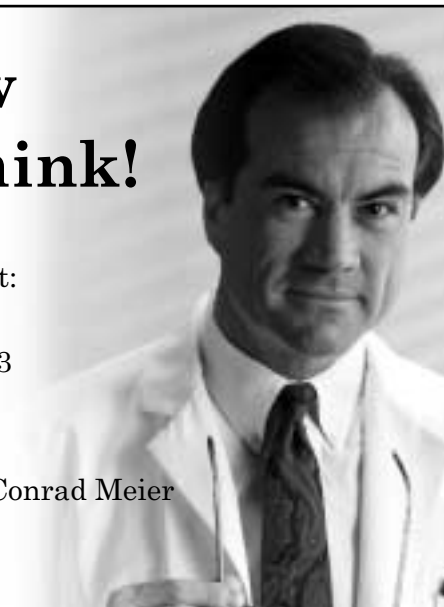
"Best of all," Matthews concluded, "the conferees have already agreed to the program as a way to get help to seniors immediately. So when will Congress and the President realize that the drug card isn't part of the solution; it is the solution?"

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.

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Millions Already Benefit from Private Rx Discount Programs

by **Conrad F. Meier**

Medicare-eligible senior citizens and disabled Americans without prescription drug coverage need not wait for Congress to act on a drug benefit. Millions of Americans already take advantage of prescription drug discount programs offered by the private sector.

Forty-eight U.S. pharmaceutical manufacturers, under the auspices of the **Pharmaceutical Research and Manufacturers Association (PhRMA)**, offer prescription drug discount cards and patient-assistance programs. In 2002, PhRMA members provided free prescription medicines to more than 5.5 million patients in the United States. More information is available on the Internet at <http://www.phrma.org>, or contact PhRMA at 1100 Fifteenth Street NW, Washington, DC 20005; telephone 202/835-3400.



Together Rx, a consortium of eight drug makers, offers about 150 brand-name drugs at 15 percent off the manufacturers' wholesale list price. The Together Rx plan is available to individuals with annual incomes of \$28,000 or less and families with annual incomes of \$38,000 or less. More information is available on the program's Web site, at <http://www.togetherrx.com/>, which reports "over 1,021,392 cardholders have saved more than \$202 million to date."

The **Share Card** offered by **Pfizer Inc.** is available with no annual fee to low-income Medicare recipients. Patients enrolled in the plan can get Pfizer prescription drugs at a cost of \$15 for up to a 30-day supply. For more information on the Share Card plan—already used by 250,000 patients—call 800/459-4156, or visit the plan Web site at <http://www.pfizersharecard.com/>.

Eli Lilly's discount drug program, **LillyAnswers**, makes available all Eli Lilly drugs except controlled substances and those not distributed by retail pharmacies. Plan participants pay \$12 for a 30-day supply. Medicare-enrolled seniors and persons with disabilities are eligible if they do not have other prescription drug coverage and meet annual income requirements: \$18,000 or less for individuals, and \$24,000 or less for households. The plan currently enrolls 100,000 patients. More information is available on the Internet at <http://www.lillyanswers.com/> or toll-free at 877/795-4559.

Called the **Orange Card**, **GlaxoSmithKline's** discount drug program provides an average 30 percent sav-

ings on all outpatient prescription drugs made by the company. **Orange Card** is available to senior citizens and disabled persons enrolled in Medicare with annual incomes of \$30,000 or less (individuals) and \$40,000 or less (households). Enrollment in the program, which currently has 100,000 participants, is free. More information is available on the Internet at <http://us.gsk.com/card/> or

by calling toll-free 888-672-6436.

Novartis, a founding member of the **Together Rx** alliance, offers the **Care Card**. Plan participants with annual incomes less than \$18,000 (individuals) and \$24,000 (couples) pay just \$12 for a 30-day supply of selected Novartis medicines. Participants with higher annual incomes—up to \$28,000 for individuals and \$38,000 for couples—can receive dis-

counts of between 25 and 40 percent off selected Novartis medicines. The **Care Card** program currently enrolls 15,000 patients. More information is available on the Internet at <http://www.careplan.novartis.com/index2.html>.

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.



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Illinois

Continued from page 1

■ sent a delegation to Canada to explore contract opportunities.

"If the federal government is not able to correct serious drug price disparities between the U.S. and the rest of the world, then it should give states the flexibility to pursue better prices on their own," Blagojevich said at a September news conference in Chicago.

Mixed Response

The response to the Blagojevich proposal has been mixed, with support and opposition coming from some unexpected quarters. Illinois State Senator Chris Lauzen, a Republican known for his conservative viewpoints, has come out in support of Blagojevich, a liberal Democrat. Chicago Mayor Richard Daley, a powerful Democrat known for his liberal politics, has come out against drug importation.

Blagojevich also has encountered opposition from the Food and Drug Administration (FDA) and U.S. House Speaker Dennis Hastert (R-Illinois), whose congressional district includes a portion of suburban Chicago. Pharmaceutical companies, Illinois retail association members, and drugstore operators also oppose the move.

Blagojevich says he wants the state to be allowed to import drugs from Canada, where the government controls drug prices, as a way to save money. Illinois last year spent about \$340 million on prescription

drugs for its 230,000 state employees and retirees and \$1.8 billion on prescription drugs for all the state's health programs combined, according to the governor's office. Blagojevich's staff estimates the state could cut those costs 30 to 50 percent by importing drugs from Canada.

"The governor of Illinois apparently wants to flaunt U.S. law and the safety concerns of the U.S. Food and Drug Administration in order to get access to cheaper drugs."

MERRILL MATTHEWS, PH.D., DIRECTOR
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

The governor's office projects a budget deficit of \$1.5 to \$2 billion through the middle of 2005. Illinois' annual state budget has climbed from \$35.8 billion in 1998 to almost \$53 billion this year.

While the state Office of Management and Budget (OMB) blames "wasteful and unchecked spending" for much of Illinois' budget problem, it also cites a 41 percent increase in Medicaid payments for prescription drugs since fiscal year 1999. "These increases are attributable to expanding enrollments, skyrocketing drug costs, and natural increases in health care costs," according to the state OMB report.

Safety at Issue

For more than a decade, the directors of the federal Department of Health and Human Services—Donna Shalala during the Clinton administration, and Tommy Thompson under the current Bush administration—have repeatedly stated they cannot guarantee the safety or quality of imported drugs.

The FDA opposes drug importation, arguing there is no way to guarantee the quality or safety of imported drugs from across borders. "There are a lot of bad drugs out there," FDA Senior Associate Commissioner William Hubbard told the *Washington Post* in response to Blagojevich. "We fear a program like (Illinois') would put people at risk."

Merrill Matthews, Ph.D., director of the Council for Affordable Health Insurance and visiting scholar with the Institute of Policy Innovation, agrees drug importation is a risky scheme. Matthews told *Health Care News*, "The governor of Illinois apparently wants to flaunt U.S. law and the safety concerns of the U.S. Food and Drug Administration in order to get access to cheaper drugs. If elected officials, sworn to uphold the law, not break it, spent as much time educating their constituents about the price variations among different local pharmacies and the availability of numerous programs for low-income households, they could help their constituents rather than putting their lives at risk."

Risky Business

There have been many, mostly under-reported, instances of tampering with prescription drugs. (See "Drug Importation

Roulette," pages 10-11.)

Earlier this year, for example, a counterfeit version of Pfizer's Lipitor, the world's top-selling cholesterol-lowering drug, was discovered in Nebraska after pharmacists and patients complained the medicine tasted unusually bitter and dissolved too quickly.

In Florida, prosecutors recently announced a grand jury had indicted 19 people on charges of watering down or selling fake drugs to storefront and Internet businesses fulfilling prescriptions for consumers.

The FDA cites incidents such as these to bolster its position that imported drugs, even from neighboring Canada, could pose an unacceptable health risk to American consumers.

Risk Aside

Prescription drugs have been a major issue for Blagojevich and Emanuel, who succeeded Blagojevich in Congress after Blagojevich ran for Illinois governor in 2002. Emanuel made health care a central issue in his campaign for Congress, and he is one of the leading proponents of a bill allowing pharmacies and drug wholesalers to import drugs from Canada without FDA approval. The measure, which passed by a single vote in the U.S. House of Representatives, is being held up in a conference committee.

The states of Maine and Vermont and the city of Springfield, Massachusetts, are also considering ways to import drugs from Canada.

Steve Stanek is an Illinois-based freelance writer. His email address is stanek@mc.net.



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- **Tax Fairness**
Equalize the tax treatment for individuals purchasing health insurance.
- **Personal Responsibility**
Increase consumer participation in health care decisions.
- **Guaranteed Access**
Everyone should have access to health insurance, along with the opportunity to maintain continuous coverage.
- **Premium and Pricing**
Establish reasonable regulation of insurance rates.
- **Liability and Responsibility**
Enact sensible medical malpractice reforms in order to discourage frivolous lawsuits.
- **Disclosure**
Patients should be informed of the cost of treatment in advance and have a stake in paying for it.
- **Education**
Well-informed consumers make better health care decisions.
- **No Mandated Benefits**
Consumers should be able to purchase insurance coverage that best meets their needs, rather than being forced to pay for benefits dictated by the political system.

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Conrad Meier

Taking Control

Many prescription drugs, brand name as well as generic, are more expensive in the United States than in other countries. That is an indisputable fact.

It is also indisputable that the newly popular approach to that problem—buying drugs from other countries, either over the Internet or by traveling to Canada or elsewhere directly—poses a safety risk that is very difficult to justify. (See my “Drug Importation Roulette” on page 10.)

Safer options are available. The politicians don’t talk about them much, because if you take advantage of these opportunities they don’t get credit for helping you save money. But the politicians also won’t take the blame if a mislabeled, counterfeit, or adulterated drug you buy over the Internet makes your condition worse ... or leaves your family with one fewer loved one to care for.

Don’t leave your health—or your prescription drug costs—in the hands of politicians. There are many things you can do to take control.

1 Shop Around

A recent survey of prescription drug pricing in Missouri discovered consumers can save up to 81 percent on their prescriptions simply by comparison shopping.

The study obtained prescription prices by calling pharmacies in Jefferson

City, St. Louis, and Sedalia in central Missouri. The pharmacies included Tolson Drug, Cordes, Bing’s, Walgreens, Medicine Shoppe, Osco, Gerbes, Schnuck’s, and Wal-Mart. Prices were collected for a 30-day supply of one of four popular prescription medications in commonly prescribed dosages.

Key findings of the survey:

- For generic prescription drugs, the pharmacy offering the lowest price was, on average, 81 percent less than the highest-priced pharmacy

- For brand-name drugs, comparison-shopping could achieve an average savings of 9.7 percent

- The lowest generic drug prices were spread evenly among supermarkets, chain drug stores, and independent retailers

- Independent drug stores offered significantly lower costs on brand-name drugs.

2 Pill-Splitting

Accomplished with an inexpensive pill-cutter available at your drugstore, pill-splitting saves money because the cost of a larger-dose tablet for some prescriptions is very nearly the same as the cost of a smaller-dose tablet.

For example, 50 milligram tablets of Zoloft, an antidepressant, cost about \$227 per 100. Buying enough for 200 days would cost \$454.

But 100 milligram tablets of Zoloft

cost about \$233 per 100. A patient could split the 100 tablets into 200 50 milligram doses, saving \$221 on that prescription alone.

“When properly implemented, pill-splitting can be a safe, viable cost-saving strategy,” noted Dr. Randall Stafford, a researcher at the Stanford Center for Research in Disease Prevention.

“Don’t leave your health—or your prescription drug costs—in the hands of politicians. There are many things you can do to take control.”

While not all drugs can be split—time-release capsules, for example, cannot be—popular medications like Lipitor, Paxil, Seerzone, Viagra, Zoloft, and Celexa can be.

Pill-splitting also saves money because a prescription lasts twice as long. A patient taking a daily 50 milligram dose of Zoloft for 200 days makes just one co-payment if she buys a 100-day supply of 100 milligram tablets. She must make two co-payments if buying two 100-day supplies of 50 milligram tablets.

3 90-Day Supply

Ask your doctor for a 90-day prescription for a drug you use for a long-term or chronic condition. Pharmacy surveys suggest buying a 90-day supply, rather than buying three 30-day supplies, can cut patient costs by approximately one-third. It’s like buying two months and getting the third free.

4 Cheaper than Canada

Forty-eight U.S. pharmaceutical companies offer free or minimal cost discount drug cards and patient assistance programs. (See “Millions Already Benefit from Private Rx Discount Programs,” page 15.) Last year alone, these companies provided free prescription medicines to more than 5.5 million patients in the United States.

5 Take Advantage of What’s Available

Senior citizens and the disabled should contact their state Departments of Health and ask about senior care, circuit breaker, or pharmaceutical assistance programs. Veterans should contact the Veterans Administration at 800/827-1000 or go online at <http://www.va.gov>.

Conrad F. Meier is managing editor of Health Care News. His email address is meier@heartland.org.

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